Indiana Department of Insurance
Filing Company Checklist
Individual Long Term Care Policy Review Standards

Association policies/certificates should be filed as GROUP, <u>not</u> individual

(This Checklist must be submitted with any LTC filing – attach as PDF Document if filing electronically)

Company Name_____ NAIC # _____

Form number(s)_____ Filing date_____

Traditional ☐ (Tax Qualified ☐ Non TQ ☐) Partnership ☐

Statute/ Regulation	***Requirement***	***N/A*** ***(If asking for special consideration on any item please address in Cover Letter)***	***Location in Submitted Documents***	***For DOI USE ONLY*** ***Yes/No Comments***
General Filing Requirements				
IC 27-1-3-15	***Filing Fee***—We will bill you quarterly for **each** form contained in the filing and for **each** company the form is filed for. The per form fee is $35 or the retaliatory fee based on your state of domicile. **PLEASE DO NOT** submit any filing fees with your filing.			
Bulletin 125	A cover letter in duplicate and one copy of all forms to be filed. The cover letter should include:			
	a) A reference "Re:" line with the insurance company's name and NAIC number, and the form number of **each** form to be filed.			
	b) If there are numerous forms in one filing, please list them on a separate sheet of paper and indicate in the reference line "see attached list." Please list the most important form first and keep the same order in related correspondence			
	c) The name of a contact person, with telephone and fax numbers. **Please include an e-mail address so that we may correspond with you by e-mail.** On all correspondence, please include NAIC number and form number. Any submission of additional forms or materials should include a separate response letter, in duplicate, for each filing being addressed.			
	d) The nature of the insurance product (e.g. Medicare Supplement, individual, small group, association group, employer group health insurance, etc.)			
Bulletin 125	A postage-paid, self-addressed envelope of adequate size to hold the "approved" or "filed" stamped duplicate correspondence and any extra copies of forms that you wish to have returned. (There is no need to send more than one copy of the forms.)			

Bulletin 125	If the filing is submitted by an outside consulting firm, a letter giving authorization to file on behalf of the company. If you are filing for multiple companies, please pre-sort the materials, by company, before sending.			
GENERAL*:*				
Required Provisions for Individual A&H Policies IC 27-8-5-3	Refer to Code for Applicable Policy Provisions			
Return of Policy Notice IC 27-8-12-12 IC 27-8-12-13	An individual LTC policyholder may return the policy within 30 days of delivery and have premium refunded if the policyholder is not satisfied for any reason. Notice of this return provision must be prominently printed on the first page or attached thereto. **Solicitation by Direct Response –** Refer to citation.			
Federal Tax Qualified Definition (TQ) 760 IAC 2-2-3.7	Refer to Citation for TQ Requirements			
Premiums 760 IAC 2-3-6	Premium increases cannot be based on the increasing age of insured at ages beyond 65 OR the duration that the insured has been covered by such policy.			
Non Partnership Policy 760 IAC 2-20-34(10)	LTC Policies that are not Partnership compliant must state so, in accordance with Rule 34(10).			
Policy Provisions				
Unintentional Lapse 760 IAC 2-3-8	Provides for notification of additional person in the event policy lapses; time frame for notification and reinstatement.			
Home Health & CC Care Benefits 760 IAC 2-6-1	Lists minimum benefit standards, limitations, and allowable exclusions for these services.			
Inflation Protection Offer 760 IAC 2-7-1(a)	Offer no less favorable than (1)one of the following: 1) Annual Compound 5% inflation 2) GPO at least 5% annual compound 3) Cover a specified % of actual or reasonable charges without maximum limit. (Additional inflation offers not less than 3%.)			
760 IAC 2-7-1-3(b)	Inflation protection continues at same level for policy benefit.			
760 IAC 2-7-13(d)	Statement on application if inflation protection is rejected.			
Preexisting Condition IC 27-8-12-10(b)	No LTC policy may exclude loss or confinement that results from pre-existing condition unless loss or confinement begins within: 12 months following effective date for insureds 65 or older on effective date OR 24 months following the effective date of an insured person under 65 on the effective date of coverage.			
IC 27-8-12-10.5	An individual LTC policy may not exclude coverage for a loss or confinement caused by a pre-existing condition unless such loss begins within 6 months of the policy effective date. A LTC policy may not exclude, by policy or rider, or reduce coverage or benefits for a specifically named or described pre-existing disease or physical condition beyond the above referenced waiting period.			
IC 27-8-12-10.6	A LTC may not be delivered or issued for delivery if it conditions eligibility for: any benefits on a prior hospitalization requirement, or on receipt of higher level of institutional care (for institutional care).			
IC 27-8-12-10.6	A LTC policy that contains a post-confinement, post-acute or recuperative benefit must clearly label, in a separate paragraph, a statement entitled “limitations or conditions on eligibility for benefits”.			
IC 27-8-12-10.6	A LTC policy or rider that conditions eligibility of non-institutional benefits on the prior receipt of institutional care must not require a prior institutional stay of > 30 days.			

IC 27-8-12-10.6	A LTC policy or rider that provides benefits only following institutionalization may not condition such benefits upon admissions to a facility for the same or related conditions within a period of < 30 days after discharge from the institution.			
Non-Forfeiture Benefit 760 IAC 2-16.1-1	Non-forfeiture offer to be included, if rejected, contingent benefit offer.			
Benefit Triggers 760 IAC 2-16.1-2 760 IAC 2-16.1-3	Benefit payments triggered by deficiency in not more than 3 ADLs or cognitive impairment. Triggers defined for TQ policy.			
Policy Termination IC 27-8-12-9	Insurer may not cancel, decline to renew or otherwise terminate a policy based solely on the age or deterioration in mental or physical health of the insured individual or certificate holder.			
DISCLOSURES				
Renewability 760 IAC 2-4-1(a)	Individual policies must contain a renewability provision, which should be displayed on the first page of policy, and clearly state the terms and any limitations.			
760 IAC 2-4-1(b)	Any riders or endorsements added to an individual policy after issue date or reinstatement or at renewal which reduce or eliminate benefits or coverage, must require a signature that the insured accepts them. The only exception is when such change is effectuated by the carrier at the written request of the insured.			
760 IAC 2-4-1(c)	Terms such as "reasonable and customary", "usual and customary" or similar must be defined in the accompanying outline of coverage.			
760 IAC 2-4-1(d)	Any policy, certificate or subscriber agreement that contains any limitation based upon pre-existing conditions must list such limitations in a separate paragraph and label as "pre-existing condition limitation".			
760 IAC 2-4-1(e)	A policy, certificate or subscriber agreement containing any limitations or conditions for eligibility (other than those prohibited by IC 27-8-12-10.6) should fully describe such conditions or limitations, including any required days of confinement, in a separate paragraph, and label the paragraph "Limitations or Conditions on Eligibility of Benefits".			
760 IAC 2-4-1(f)	Life insurance policies which provide an accelerated benefit for LTC must include a disclosure statement (at time of application and at the time the benefit request is submitted) that receipt of such benefit may be taxable and assistance should be sought from the individual's tax advisor. Disclosure should be prominently displayed on the first page of the policy or rider and on any related documents			
760 IAC 2-4-1(g)	ADLs and Cognitive Impairment shall be used as benefit triggers, described, and labeled.			
760 IAC 2-4-1(h) & (i)	Tax status of policy shall be disclosed in policy and outline of coverage.			
Notice To Buyer 760 IAC 2-15-1(a)(3)	Include verbatim "Notice to Buyer" on 1st page of outline of coverage and policy			
Rating Practices 760 IAC 2-4-2(e)	Disclose rating practices to applicant (Refer to 2-19.5-1 and 2-19.5-2 for format).			
Marketing Standards 760 IAC 2-15-1(a)(6)	Include information on SHIP (State Health Insurance Program) and ILTCIP (Indiana Long Term Care Insurance Program) as separate document or as additional item on Outline of Coverage.			
APPLICATION				
Medication 760 IAC 2-5-1	Application should list name of medicine if applicable.			
Supplemental Information	1) Use verbatim "Caution" statement for policy			

760 IAC 2-5-2	issue based on answers. 2) Use ”Caution” statement for validity of answers.			
Questions 760 IAC 2-8-1	Application questions to use regarding existing coverage and replacement.			
Replacement 760 IAC 2-8-3 760 IAC 2-8-4	Required notice for replacement of existing policy. (Refer to citation for format.)			
Replacement 760 IAC 2-8-6	Required notice for replacement for life insurance with long term care.			
OUTLINE OF COVERAGE IC 27-8-12-14(E) 760 IAC 2-7-4 760 IAC 2-17-1	Refer to citations for Outline of Coverage requirements and contents.			
SUITABILITY 760 2-15.5-1(d)	Submit “Long Term Care Personal Worksheet” to be reviewed. Refer to 760 2-19.5 for format.			
STANDARD FORMS 760 IAC 2-19.5	Required Forms to Be Given Applicant			
760 IAC 2-19.5-1	Long Term Care Personal Worksheet (Refer to citation for format)			
760 IAC 2-19.5-2	Potential Rate Increase Disclosure Form (Refer to citation for format)			
Disclosure Form 760 IAC 2-19.5-3	Things You Should Know Before You Buy Long Term Care Insurance (Refer to citation for format)			
Indiana Long Term Care Partnership Policies (ILTCIP) 760 IAC 2-20	**These Requirements apply only to Indiana Partnership (“qualified”) Filings**			
Policy Requirements				
Qualification 760 IAC 2-20-33	Policies, riders and certificates that are filed in order to participate in the Indiana LTC Partnership Program must comply with specific requirements and cannot be marketed as Partnership compliant without approval.			
Marketing Standards 760 IAC 2-20-34(1)(A-E)	Standards and provisions for policies, certificates, and riders. Refer to citation for format.			
760 IAC 2-20-34(2)	Applicants for Partnership facility policies and certificates must sign a form confirming that they were offered a qualifying integrated policy or certificate and declined the option (language set out in Rule).			
760 IAC 2-20-34(3)	Applicants must be given option to have application date be issued as the effective date.			
760 IAC 2-20-34(4)	Applicants must be provided, upon delivery of the qualified policy or certificate, a complete description of the asset protection options and a description of Medicaid, in a format prescribed by OMPP.			
760 IAC 2-20-34(5)	Applicants must sign confirming the policy is dollar for dollar not total asset protection and that is their intention.			
760 IAC 2-20-34(7)	Include a statement on the outline of coverage, the policy or certificate application, and the front page of the policy or certificate rider, in bold face and in a separate box, stating that the policy qualifies for Medicaid Asset Protection (see Rule for language).			
760 IAC 2-20-34(8)	For all LTC facility policies or certificates, must state, on outline and front page, “Long Term Care Facility Policy (Certificate)”. Also must include statement as set out in Rule Sec (9).			
760 IAC 2-20-34(9)	Include a statement on rider in bold face and in a separate box stating rider qualifies for Medicaid Asset Protection (see Rule for exact language)			
760 IAC 2-20-33	Policies, riders and certificates that are filed in order to participate in the Indiana LTC Partnership Program must comply with specific requirements and cannot be marketed as Partnership compliant without approval.			

760 IAC 2-20-35	To qualify as a Partnership Plan, a policy or Certificate must: 1) Provide that maximums benefits are available in dollars and not days of care, 2) Include a 5% compound inflation protection benefit. Applicants age 75+may purchase 5% simple inflation protection. 3) Provide that the unused maximum benefit amount increase proportionally with the inflation protection requirements set out above.			
Required Provisions 760 IAC 2-20-36	Refer to citation for provisions.			
Minimum Benefit and Provisions 760 IAC 2-20-36.1	To be a qualified **Integrated** Partnership policy or certificate, it must: 1) Have maximum benefit amount = to at least 365 x the minimum daily nursing facility benefit, and; 2) Offer maximum benefit amount option equivalent to 365 x minimum daily nursing facility benefit, and; 3A) Offer daily nursing benefit at least 75% of average daily rate of private pay rate in nursing facilities rounded to the next highest $5 or $10 increment, but no policy shall pay in excess of actual charges, and; 3B) Daily home and community based benefit of at least 50% of daily nursing facility benefit contained in the policy, but may not pay in excess of actual charges, and; 3C) Daily home and community based benefits may not exceed daily nursing facility benefit, and; 4) Provide benefits equal to at least 75% of the per diem cost incurred by insured on expense incurred basis policy. 5) Provide that benefits can be used to purchase nursing facility care or community and home based care (which includes home health nursing, aide services, attendant care, respite care and adult day care), and; 6) All home and community based services shall include case management services delivered by a case management agency, which may be limited, but shall not be less than 13 x daily nursing home benefit a year. 7) Benefits for Residential Care Facilities must: (A) Provide a daily RCF benefit of at least 75% and no more than NF benefit (B) On expense incurred basis, RCF not to exceed 75% of per diem cost. (C) Provide provision to purchase care in NF or RCF.			
Minimum Standards & Provisions for Facility Policy or Certificate 760 IAC 2-20-36.2	1) Offer max benefit option equivalent to 365 x the minimum daily nursing facility benefit. 2) Max benefit must be at least 365 x minimum daily nursing facility benefit. 3) Daily nursing facility benefit of at least 75% of the average daily private pay rate in nursing facilities rounded to the nearest $5 or $10 increment. May not pay benefits in excess of actual charges. 4) If issued on expense incurred basis, provide daily nursing facility benefits which are equal to at least 75% of the per diem cost incurred by the insured. 5) May include benefits for residential care facilities, in a LTC facility policy			
760 IAC 2-20-36.2	Insurers may include benefits for residential care facilities in a LTC facility policy or certificate, BUT, then they must: 5A) Provide daily residential care benefit of at least 50% of (and no more than) the daily nursing facility benefit, and; 5B) If issued on expense incurred basis, must provide daily benefit which does not exceed 50% of the per diem cost insured, and;			

	5C) Include a provision that policy or certificate benefits can be used to purchase care in a nursing facility or residential care facility.			
Minimum Standards for Riders 760 IAC 2-20-36.3(c)	Minimum standards for LTC Partnership RIDERS: Partnership Riders that provide home and community based services must provide, at minimum: home health nursing, home health aide services, attendant care, respite care and adult day care.			
760 IAC 2-20-36.3(d)	Home and community based services covered through such Rider must include case management services delivered by a case management agency. Rider may limit such benefits, but not less than 13 x daily nursing home benefit per year, and case management benefits cannot count towards the maximum policy/certificate benefit.			
760 IAC 2-20-36.3(e)	Such Riders must also (as of effective date): (1) Include a minimum daily home and community based benefit of 50% of the current daily nursing facility benefit of the LTC facility policy/certificate. (2) Provide that the daily home & community based benefit not exceed the current daily nursing facility benefit. (3) If issued on an expense incurred basis, provide benefits = to at least 75% of the per diem cost incurred.			
760 IAC 2-20-36.3(f)(1) & (2)	Provide a max benefit of at least 50% of the then current max total benefit amount of the LTC policy/certificate, but not exceeding such max benefit.			
General Regulatory Issues	Under the authority provided by IC 27-4-1-4 the Department monitors various issues that have been determined to be unfair, misleading or potentially constitute unfair trade practices. The following issues will also be reviewed.			
Application questions 27-8-5-1(d)(2) 27-8-5-1.5(l)	1. Questions regarding an applicant's health cannot inquire about non-specific conditions prior to the most recent five years. 2. Questions inquiring if an applicant has had signs or symptoms of a condition are not permitted. 3. Small employer applications may not require applicants declining coverage to complete health questions.			
Arbitration 27-8-5-1(d)(2)	Mandatory and/or binding arbitration provisions are prohibited.			
First manifest language 27-8-5-19(c)(6) 27-8-5-2.5 27-8-15-27	Typically first manifest type language creates a permanent exclusion of coverage related to a condition present any time prior to the effective date of coverage contrary to any pre-existing condition provisions included in the form. Such inconsistencies are not permitted.			
Foreign language forms Bulletin 106	Foreign language forms must comply with Bulletin 106.			
Large endorsements 27-8-5-1(d)(2) 27-8-5-1.5(l)	The Department does not allow use of large or confusing endorsements to bring contracts into compliance. In such cases the entire contract should be refiled to incorporate the multiple changes. On a similar note, Indiana specific certificates should be filed rather than file an endorsement to revise another state's certificate.			
Open endorsements 27-8-5-1(d)(2) 27-8-5-1.5(l)	Highly flexible or "blank check" type endorsement forms that provide unlimited ability to revise forms without regulatory review are not allowed.			
Privacy of health information 27-8-5-1(d)(2) 27-8-5-1.5(l)	Employers cannot be asked to reveal or certify the accuracy of any knowledge they may have regarding an individual's health condition.			
Various fees 27-8-5-1(d)(2) 27-8-5-1.5(l)	Fees charged to accept or process an application are not allowed. One-time fees such as may be charged to issue a policy are			

	acceptable providing they are clearly labeled and accompanied by a disclosure that the fee is fully refundable if the policy is not issued, not taken or returned during the "free look" period.			
Bulletin 103	No full and final discretion clauses except where policy is governed by ERISA			
760 IAC 1-8	Use of terms "Noncancellable" and "Guaranteed Renewable" must not be misleading			
27-8-5-1(d)(2) 27-8-5-1.5(l)	The policy form cannot contain provisions that are unjust, unfair, inequitable, misleading, or deceptive, or that encourage misrepresentation of the policy.			

I hereby certify, pursuant to IC 27-8-5-1.5(i)(1)(C), that the policy form submitted with this checklist meets all requirements of Indiana law.

Filer: _____

Printed: _____

Company: _____

Title: _____

Date: _____